New Jersey Department of Children and Families Policy Manual

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Issuance:	1500	**Psychotropic Medication**	

Purpose

This issuance establishes policy and procedures related to the prescribing, use and monitoring of psychotropic medication for minor clients.

Policy

A) Basic Principles

This policy is grounded in the Department's values as expressed in the DCF Case Practice Model and DCF's Child Health Values.

DCF has identified essential core values and principles for working with children and families. These values are:

- Safety: Child safety and health is paramount in our work, and children are, first and foremost, protected from abuse and neglect.
- Permanency: Children do best when they have strong families, preferably their own, and when that is not possible, a stable relative, foster or adoptive family.
- Well-Being: We will offer relevant services to children and families to meet their identified needs and promote children's development, education, physical and mental health.
- Most families have the capacity to change with the support of individualized service responses.

- Where possible, children should be placed in the least restrictive setting within their own communities.
- Government cannot do the job alone; real partnerships with people and agencies involved in a child's life – for example, families, pediatricians, teachers, child care providers - are essential to ensure child safety, permanency and well-being, and to build strong families.

Child health is a critical part of the recent child welfare reform efforts in New Jersey. Reform efforts around child health, including this manual are grounded in the DCF's child health values:

- *Child centered care*: Care should be provided in a manner sensitive to the child. When possible, adolescents should be included in their health care planning.
- *Continuity* of care for children is important and DCF strives to strengthen coordination across systems of care in support of transitions—transitions coming into care, during care, and into permanency.
- *Access* to providers who have the capacity to serve our children, and accessing providers within timeframes that meet the needs of children is critical.
- *Quality:* DCF expects children to receive high quality healthcare, inclusive of physical, mental/behavioral, and dental health.
- *Integration*: The health care needs of a child need to be integrated into services to the child as a whole.
- *Partnership:* DCF recognizes that to operationalize our child health values the partnership and collaboration of many in our communities is required.

B) Psychotropic Medication Generally

It is the express requirement of the New Jersey Department of Children and Families that psychotropic medication only be prescribed to the children and youth as part of a comprehensive treatment plan that includes other therapeutic interventions and modalities.

Except in rare instances –such as an acute psychotic break – medication should be considered only after other, less physiologically intrusive interventions have been tried.

Under no circumstances shall psychotropic medication be utilized for purposes of discipline or restraint or the convenience of staff members or resource parents.

C) Treatment Plan

Because children who have a mental health need require a variety of interventions to manage their symptoms and develop appropriately, a formal treatment plan is required. A formal treatment plan is the culmination of the treatment team's work to identify the problem, specify target symptoms and treatment goals, develop interventions that are realistic for the child and family, and provide for reassessment. It represents an agreement to work together toward a mutually agreed upon set of goals.

The treatment plan is developed in collaboration with the child (to the extent feasible given the age, maturity and comprehension of the child), family and other treatment team members based on the findings of the health professional. The treatment plan should be child focused and family centered.

A treatment plan must include:

- The child's diagnosis; and baseline strengths and needs;
- Target symptoms and treatment goals stated in a way that can be measured;
- Treatment interventions, including medications (if part of treatment plan). If medications are utilized, the dosage and monitoring schedule must be specified; and
- Plan for periodic review and reassessment.

D) Authorized Prescribers

Psychotropic medications for children in out of home placement may only be prescribed by board certified or board eligible specialists in psychiatry (child and adolescent recommended); neurodevelopmental pediatrics, or pediatric neurology, or Advanced Practice Nurses (APNs) certified in Psychiatry/Mental Health pursuant to a joint protocol with a collaborating board certified or eligible specialist with one of those areas of expertise. A Pediatrician or Family Physician, Board Certified Pediatric Advanced Practice Nurse, Board Certified Family Advanced Practice Nurse or Board Certified Psychiatric Advanced

Practice Nurse may prescribe stimulants or other FDA approved ADHD medications to children who have been diagnosed with uncomplicated Attention Deficit Hyperactivity Disorder.

E) Baseline Evaluation Required and Components

When the screening and assessment identifies the possible need for psychopharmacological intervention, a thorough baseline evaluation is required and must include:

- Developmental, medical, educational and behavioral health history.
- Physical Examination, including vital signs and growth parameters
- Mental Status Examination:
- Diagnosis:
- Goals and Target Symptoms:
- Plan for Initiating and Monitoring Medication:

The baseline evaluation of a child with uncomplicated ADHD must include the same components, but the mental status examination may be limited. The baseline evaluation of a child with uncomplicated ADHD must include the child's medical, developmental and educational history, physical examination, diagnosis, goals and target symptoms, and plans for initiating, monitoring, and re-assessing medication. If concerns about a comorbid condition is identified, referral to a specialist is required.

Detailed information on the baseline evaluation report, see procedures below.

F) Consent to Treatment

Prescribers must first seek consent from birth parents or legal guardians. The LOM may provide consent for children who are in out-of-home placement under CP&P supervision when:

- parental rights have been terminated;
- A court has provided specific authority to CP&P to provide such consent;
- In an emergency situation if the parents are unavailable.

G) Informed Consent

Prescribers must provide adequate information to the child, parent, caregiver and guardian for those persons to be able to make an informed choice to consent to psychotropic medication. This includes information about the anticipated benefits, risks, the range of doses, effects to anticipate, and what would constitute a reasonable trial. Written information should be supplied when available and in the primary language of the family. Information about serious adverse effects to watch for and when and how to contact the prescriber must be discussed.

H) Prescribing Guidelines

Unless compelling reason exists to do otherwise, a child should have a trial of an FDA approved medication before being prescribed medications that have not been approved for use in the pediatric population.

Medication dosages should be kept within FDA guidelines (when available). The rationale for any deviation must be documented the child's treatment records.

Treatment with a single medication for a single symptom or disorder should be tried before treatment with multiple medications is considered. The decision to treat a child with more than one medication from the same class (e.g. two anti-psychotic medications) should be supported by writtendocumentation in the child's health record. A clinician prescribing more than 3 psychotropic medications to one child must justify and document the rationale for doing so in the child's treatment plan.

There should be an effort, over time, to adjust medications doses to the minimum dose at which a medication remains effective and side effects are minimized. Periodic attempts at taking the child off medication should also be tried and, if not, the prescribing clinician is to document the rationale for declining to do so.

I) Monitoring and Discontinuation Guidelines

Once a drug is prescribed, the prescriber must ensure its availability to the child, monitor his or her response, maintain a documentary record of treatment, and review medication use.

A child on psychotropic medication should be seen by the prescriber at least once a month when the medication is initiated and until a stable dose and effect is reached.

Once a child is stabilized on a medication the prescriber should see that child no less often than once every three months. Children in acute settings, displaying unsafe behavior, experiencing significant side-effects, or not responding to a medication trial or in an active phase of a medication trial should be seen more frequently.

Except when a child's health and safety are at risk, discontinuation of medications should be done gradually to allow the child to adapt to physiological change.

Procedures

1) **Psychiatric Evaluation and Diagnosis**

When the screening and assessment of a child's need for mental health services identifies the possible need for psychopharmacological intervention as part of the treatment plan, a thorough baseline evaluation is essential to the success of the intervention. With the exception of stimulant medication for uncomplicated ADHD, an initial evaluation and diagnosis by a psychiatrist, neurodevelopmental pediatrician or pediatric neurologist is required before the prescription of psychotropic medication. This baseline evaluation includes:

History:

The decision to treat with psychotropic medication should be based on a thorough mental health assessment and psychiatric evaluation that considers the individual's history including development, psychiatric history, medical history, past medications, allergies and drug reactions, and complete current medications including non-psychotropic medications. The contribution of physical illness or trauma history to the child's presentation must be considered. Consultation with other professionals who are treating the child, including teachers, therapists, primary care physicians, or medical specialists may be required. Psychiatric symptoms must be considered in the context of concurrent developmental and medical problems and medications.

Physical Examination:

As part of the decision to initiate a medication trial, a recent physical examination is required and must include height, weight, body mass index, and vital signs. When indicated by history, physical examination or psychiatric evaluation, the child may require medical specialty consultation and testing. Cardiac, endocrinological, neurological or other consultations might be indicated.

Baseline laboratory assessment is advisable both to rule out subtle medical conditions that may contribute to symptoms, and to establish a baseline for possible adverse effect development. A negative pregnancy test should be obtained before initiating medication for a child/adolescent of child-bearing age.

A baseline drug screen should be obtained when indicated.

If the prescriber has not conducted this examination, the prescriber is to review the examination records and this review is to be recorded.

Mental Status Examination:

The mental status evaluation of a child must be sensitive to the age, developmental stage and current status of the individual child.

Child psychiatric diagnosis often requires multiple sessions to gain the trust of the child and allow for a clear picture of the youngster's mental status to be obtained.

Ideally the child's history should be elicited first, and then the child interviewed both with and without parents or caregivers present. Often ancillary methods of assessment, including drawing and play therapy, may be required to elicit symptoms.

Diagnosis:

In developing a working diagnosis the prescriber must consider the child's symptoms, developmental history, medical history, family history, past experiences, current functioning in all settings, and current mental status.

Goals and Target Symptoms:

After a thorough assessment of the child's status has been completed, a working diagnosis is formulated, and specific target symptoms are identified. Target symptoms should be specific; when possible, they should be observable and quantifiable. The use of checklists to establish a baseline and monitor progress is recommended.

The prescriber, child and caregiver should arrive at an agreement about the current severity and frequency of the target symptoms and agree on reasonable goals. It is important for the child and guardian to participate in the discussion of the target symptoms, as they will be the primary persons observing for pharmacological effect. Similarly, teachers and other professionals who have ongoing contact with the child may be asked for their observations of medication effects.

Initiating Medication

The decision to treat with psychotropic medication is guided by the child's diagnosis, strengths and needs, and considers the resources of the unique child, family and community.

Medication decisions must be appropriate to the diagnosis of record, based on target symptoms. Medication must be prescribed as part of a treatment strategy that includes other non-pharmacological interventions, and may not be prescribed instead of instituting other non-pharmacological treatments that the individual child needs. Children and adolescents in state custody must have access to a range of effective psychosocial, psychotherapeutic and behavioral treatments aswell as pharmacotherapy when indicated.

Evaluation of Children with Uncomplicated ADHD

This policy allows physicians with board certified or board eligible expertise in pediatrics and family medicine, and APNs certified in those fields, to prescribe

psychotropic medications to children with uncomplicated Attention Deficit Hyperactivity Disorder. Prescribing privileges for these professionals is limited to the prescription of stimulants and other medications that have FDA approval for ADHD indications.

The diagnosis and treatment of Attention Deficit Hyperactivity Disorder is within the scope of practice of Pediatricians and Family Practice Physicians, and APNs with parallel credentials. The evaluation at the initiation of treatment of uncomplicated Attention Deficit Hyperactivity Disorder in this setting may differ in scope and presentation from the elements of a psychiatric evaluation as described above.

The assessment of possible Attention Deficit Hyperactivity Disorder happens within the context of the general medical care of the child. The history and physical examination may be embedded within the child's chart.

The mental status component may not be formally noted, but the prescriber is expected to look for other factors including anxiety, trauma or depression that could be contributing to the child's presentation as inattentive or hyperactive. If concern about a comorbid evaluation is identified, referral to a specialist is required.

The determination of the diagnosis, goals and target symptoms, and plan for initiating and monitoring medication may take a different form, such as a progress note referencing the basis for establishing the diagnosis, the choice of medication, and the plan for re-assessment.

2) Medication Safety Guidelines for Prescribers

Every child or adolescent has unique needs that require individualized treatment planning. It is the intent of the Department of Children and Families that children subject to this policy receive necessary mental health care, including psychotropic medications, in a rational, safe and timely manner.

The following represent guidelines for prescribers for prudent and rational psychopharmacological treatment of children and adolescents. In addition, these Guidelines are meant to be utilized by Department of Children and Families' staff to assist in the management of the Informed Consent

process and the active participation in treatment plan meetings. The rationale for this treatment must be documented in the child's health record and be thoroughly reviewed during treatment team meetings.

- Preference is given to beginning with medications that have been FDA approved for a child's given age group and diagnosis before progressing to other medications.
- Medications that have more data regarding safety and efficacy are preferred over newly FDA-approved medications. Unless compelling reason exists to do otherwise, a child should have a trial of an FDA approved medication before being prescribed medications that have not been approved for use in the pediatric population.
- Medication dosages should be kept within FDA guidelines (when available). Any deviation from FDA guidelines is to be documented with the underlying rationale in the child's treatment records.
- Treatment with a single medication for a single symptom or disorder should be tried before treatment with multiple medications is considered. The use of two or more medications for the same symptom or disorder is discouraged and requires specific documentation, from the prescriber, in the child's health record. An exception to this principle is when a short acting form of a stimulant is used to augment the benefits of a long acting preparation.
- Only one medication should be changed at one time. This allows the prescriber to attribute changes to the medication change. An exception to this principle is when a child is being tapered off one medication and onto another.
- Medications should be initiated at a low dose and increased gradually. The clinical wisdom, "start low and go slow" is particularly relevant when treating children in order to minimize side effects and to observe for therapeutic effects.
- Periodic monitoring of the child's vital signs and growth parameters (including height, weight, BMI and growth chart) is necessary to ensure healthy development while on medication.
- Regular monitoring of cardiac indices, laboratory values, assessments for abnormal involuntary movements, and other measures of adverse effects must be obtained and reviewed.

- The decision to treat a child with more than one medication from the same class (e.g. two anti-psychotic medications) should be supported by written documentation in the child's health record from the prescriber and may warrant review by the DCF's Child and Adolescent Psychiatrist.
- A clinician prescribing more than 3 psychotropic medications to one child must justify and document the rationale for doing so in the child's treatment plan and warrant review of the DCF's Child and Adolescent Psychiatrist.
- There should be an effort, over time, to adjust medications doses to the minimum dose at which a medication remains effective and side effects are minimized. Periodic attempts at taking the child off medication should also be tried and, if not, the prescribing clinician is to document the rationale for continuing the medication in the child's treatment plan.